AMENDED IN ASSEMBLY APRIL 18, 2007

AMENDED IN ASSEMBLY MARCH 29, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

# ASSEMBLY BILL No. 8

**Introduced by Assembly Member Nunez**

December 4, 2006

An act to *amend Section 6254 of, and to* add Section 12803.2 to, the Government Code, to *amend Sections 1363 and 1378 of, and to* add Article 3.11 (commencing with Section 1357.20) to Chapter 2.2 of Division 2 of, the Health and Safety Code, to amend Sections *10607,* 12693.43, 12693.70, 12693.73, and 12693.755 of, to add Sections ~~12693.55~~ *10293.5, 12693.55,* and 12711.1 to, to add Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to add Part 8.8 (commencing with Section 2200) to Division 2 of the Labor Code, to add Chapter 11 (commencing with Section 19900) to Part 10.2 of Division 2 of the Revenue and Taxation Code, to amend Section 131 of, and to add Section 976.7 to, the Unemployment Insurance Code, and to amend Sections 14005.23, 14005.30, and 14008.85 of, to add Sections 14005.33, 14005.34, and 14124.915 to, and to add Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 8, as amended, Nunez. Health care coverage: employers and employees.

(1) Existing law creates the California Health and Human Services Agency.

This bill would require the agency to encourage fitness, wellness, and health promotion programs and to evaluate and monitor the state's progress on increasing the coverage of uninsured persons. The bill would also require the agency, in consultation with the Board of Administration of the Public Employees' Retirement System and health provider groups, to develop health care provider performance measurement benchmarks, as specified.

(2) Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would, as of January 1, 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a purchasing pool for health care coverage *by employers* and be administered by the Managed Risk Medical Insurance Board. The bill would generally require employers to ~~arrange for the provision of health care to employees and dependents~~ *make health care expenditures, as specified, in an amount* that is equivalent to an unspecified percentage of the employer's total social security wages *for either full-time or part-time employees, or both*, or, alternatively, to elect to ~~have health care coverage provided through Cal-CHIPP upon payment of~~ *pay* an employer fee of that equivalent amount *for the applicable group of employees, who would be required to enroll in Cal-CHIPP, subject to certain exceptions*. The bill would require employers to set up a pretax Section 125 account under federal law for each employee to pay health ~~benefit costs~~ *insurance premiums*. Revenues from the employer fees would be collected by the Employment Development Department for deposit in the California Health Trust

Fund created by the bill, and moneys in the fund would be continuously appropriated to the board for the purposes of the bill. The bill would require the board to offer Cal-CHIPP enrollees a choice of various health plans. ~~The bill would require individuals who are employed and who are offered health care by their employer to accept that arrangement and would require employers to enroll an employee in the lowest cost plan offered by the employer if the employee does not select an option.~~ *The bill would exempt certain writings of the board from disclosure under the Public Records Act.*

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program. The bill would also expand the number of persons eligible for the Medi-Cal Program. The bill would delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child must meet citizen and immigration status requirements applicable to the program under federal law, thereby creating a state-only element of the programs. The bill would require the State Department of Health Care Services to seek any necessary federal ~~waiver~~ *approval* to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill would require the Healthy Families Program and the Medi-Cal program, as of July 1, 2008, and subject to available funding, to offer a premium assistance benefit and a wraparound benefit to certain persons who are eligible for either of the programs and who are offered employer-provided health coverage. The bill would enact other related provisions. Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

(3) The bill would enact various health insurance market reforms, to be operative July 1, 2008, including requirements for limited guaranteed issue, simplified benefit designs, *modified small employer coverage, modified disclosures,* and other related changes. *The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to adopt regulations by July 1, 2009, to require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care services and not on administrative costs.* Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The bill would also state the intent of the Legislature that all health care service plans and health insurers and providers shall adopt standard electric medical records by January 1, 2012.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

SECTION 1. It is the intent of the Legislature to accomplish the goal of universal health care coverage for all California residents within five years. To accomplish this goal, the Legislature proposes to take all of the following steps:

(a) Ensure that Californians have access to affordable, comprehensive health care coverage, including all California children regardless of immigration status, with subsidies for Californians with low incomes.

(b) Leverage available federal funds to the greatest extent possible through existing federal programs such as Medicaid and the State Children's Health Insurance Program in support of health care coverage for low-income and disabled populations.

(c) Maintain and strengthen the ~~employer-based~~ health insurance system and improve availability and affordability of private health care coverage for all purchasers through (1) insurance market reforms; (2) enhanced access to effective primary and preventive services, including management of chronic illnesses; (3) promotion of cost-effective health technologies, and (4) implementation of meaningful, systemwide cost containment strategies.

(d) Engage in early and systematic evaluation at each step of the implementation process to identify the impacts on state costs, the costs of coverage, employment and insurance markets, health

delivery systems, quality of care, and overall progress in moving toward universal coverage.

*SEC. 2. Section 6254 of the Government Code is amended to read:*

6254. Except as provided in Sections 6254.7 and 6254.13, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary course of business, if the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to any of the following:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any

investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes. However, state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (b) of Section 13951, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflects the analysis or conclusions of the investigating officer.

Customer lists provided to a state or local police agency by an alarm or security company at the request of the agency shall be construed to be records subject to this subdivision.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or

requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code. However, the address of the victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph may not be used directly or indirectly, or furnished to another, to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury. Nothing in this paragraph shall be construed to prohibit or limit a scholarly, journalistic, political, or government use of address information obtained pursuant to this paragraph.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records, the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(*l*) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's Legal Affairs Secretary. However, public records shall not be transferred to the custody of the Governor's Legal Affairs Secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public database maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the

financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application that are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, that reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. If a contract for inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for

other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's Office. The committee and that office shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places and records of Native American places, features, and objects described in Sections 5097.9 and 5097.993 of the Public Resources Code maintained by, or in the possession of, the Native American Heritage Commission, another state agency, or a local agency.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of ~~Health Services~~ *Public Health* pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) (1) Information contained in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant's medical or psychological history or that of members of his or her family.

(2) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to

Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(3) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(v) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695) and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after they have been fully executed.

(B) If a contract for health coverage that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and

that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1998, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

(5) The exemption from disclosure provided pursuant to this subdivision for the contracts, deliberative processes, discussions, communications, negotiations with health plans, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff shall also apply to the contracts, deliberative processes, discussions, communications, negotiations with health plans, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of applicants pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code.

(z) Records obtained pursuant to paragraph (2) of subdivision (c) of Section 2891.1 of the Public Utilities Code.

(aa) A document prepared by or for a state or local agency that assesses its vulnerability to terrorist attack or other criminal acts intended to disrupt the public agency's operations and that is for distribution or consideration in a closed session.

(bb) Critical infrastructure information, as defined in Section 131(3) of Title 6 of the United States Code, that is voluntarily submitted to the California Office of Homeland Security for use by that office, including the identity of the person who or entity that voluntarily submitted the information. As used in this subdivision, "voluntarily submitted" means submitted in the absence of the office exercising any legal authority to compel access to or submission of critical infrastructure information. This

subdivision shall not affect the status of information in the possession of any other state or local governmental agency.

(cc) All information provided to the Secretary of State by a person for the purpose of registration in the Advance Health Care Directive Registry, except that those records shall be released at the request of a health care provider, a public guardian, or the registrant's legal representative.

*(dd) (1) Records of the Managed Risk Medical Insurance Board relating to activities governed by Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.*

*(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code on or after January 1, 2008, shall be open to inspection one year after they have been fully executed.*

*(B) If a contract entered into pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.*

*(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.*

*(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's Office. The committee and the office shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).*

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act (29 U.S.C. Sec. 158).

~~SEC. 2.~~

*SEC. 3.* Section 12803.2 is added to the Government Code, to read:

12803.2. (a) The California Health and Human Services Agency shall encourage fitness, wellness, and health promotion programs that promote safe workplaces, healthy employer practices, and individual efforts to improve health.

(b) The California Health and Human Services Agency shall establish an aggressive and timely evaluation and oversight effort to carefully monitor progress on key benchmarks and indicators relative to extending health care coverage to uninsured individuals under the ~~California Fair Share Health Care Act~~ *act enacting this section in the 2007–08 Regular Session of the Legislature*. Key indicators shall include, but need not be limited to, annual assessment of the impacts on coverage, the cost of coverage, state costs, employment and insurance markets, health care delivery systems, and quality of care. In 2013, the agency shall conduct a comprehensive evaluation to determine if the goals are being met and what adjustments or additional steps are necessary. The agency shall keep the Legislature informed on a regular basis of its efforts pursuant to this subdivision.

(c) The California Health and Human Services Agency, in consultation with the Board of Administration of the Public Employees' Retirement System, and after consultation with affected health care provider groups, shall develop health care provider performance measurement benchmarks and incorporate these benchmarks into a common pay for performance model to be offered in every state-administered health care program, including, but not limited to, the Public Employees' Medical and Hospital Care Act, Healthy Families, the ~~Managed~~ *Major* Risk Medical Insurance Program, Medi-Cal, and Cal-CHIPP. These benchmarks shall be developed to advance a common statewide framework for health care quality measurement and reporting, including, but not limited to, measures that have been approved by the National Quality Forum (NQF) such as the Health Plan Employer Data and Information Set (HEDIS) and the Joint

Commission on Accreditation of Health Care Organizations (JCAHO), and that have been adopted by the Hospitals Quality Alliance and other national and statewide groups concerned with quality.

~~SEC. 3.~~

*SEC. 4.* Article 3.11 (commencing with Section 1357.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.11. Insurance Market Reform

~~1357.20. The requirements of this article shall apply notwithstanding any other provision of law.~~

~~1357.21.~~

*1357.20.* Effective July 1, 2008, every full-service health care service plan that offers, *markets,* and sells health plan contracts to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board in consultation with the Department of Insurance and the Department of Managed Health Care. A health care service plan subject to this section may not exclude a potential enrollee from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1 of the Insurance Code.

~~1357.22.~~

*1357.21.* (a) Every full-service health care service plan shall offer, *market,* and sell all of the uniform benefit plan designs made available through Cal-CHIPP pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code to purchasers in each region and in all individual and group markets where the plan offers, markets, and sells health care service plan contracts, consistent with statutory and regulatory rating and underwriting requirements applicable to the respective individual and group markets.

(b) This section shall not preclude a plan from offering other benefit plan designs in addition to those required to be offered under subdivision (a).

~~1357.23.~~

*1357.22.* It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient's personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health care service plans and providers shall adopt standard electronic medical records by January 1, 2012.

*1357.23. Effective January 1, 2008, all requirements in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan's contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health care service plan contracts offered to all employers with 250 or fewer eligible employees, except as follows:*

*(a) For small employers with 2 to 50, inclusive, eligible employees, all requirements in that article shall apply.*

*(b) For employers with 51 to 250, inclusive, eligible employees, all requirements in that article shall apply, except that the health care service plan may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 250, inclusive, eligible employees.*

*1357.24. The requirements of this article shall not apply to a specialized health care service plan or a Medicare supplement contract.*

*SEC. 5. Section 1363 of the Health and Safety Code is amended to read:*

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between

plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about

the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group ~~consisting of 25 or fewer individuals~~, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

*SEC. 6. Section 1378 of the Health and Safety Code is amended to read:*

1378. No *full-service health care service* plan shall expend for administrative costs in any fiscal year an excessive amount of the aggregate dues, fees and other periodic payments received by the plan for providing health care services to its subscribers or enrollees. The term "administrative costs," as used herein, includes costs incurred in connection with the solicitation of subscribers or enrollees for the plan. *The director shall adopt regulations no later than July 1, 2009, to define "administrative costs" and "health*

*care services" so that at least 85 percent of aggregate dues, fees, and other periodic payments received by a full-service plan are spent on health care services. This section shall not apply to Medicare supplement contracts.*

This section shall not preclude a plan from expending additional sums of money for administrative costs provided such money is not derived from revenue obtained from subscribers or enrollees of the plan.

*SEC. 7. Section 10293.5 is added to the Insurance Code, to read:*

*10293.5. (a) The commissioner shall adopt regulations no later than July 1, 2009, to define "administrative costs" and "health care services" so that at least 85 percent of health insurance premium revenue received by a health insurer is spent on health care services.*

*(b) As used in this section, health insurance shall have the same meaning as in subdivision (b) of Section 106.*

*(c) The requirements of this chapter shall not apply to a Medicare supplement, vision-only, dental-only, or Champus-supplement insurance or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.*

*SEC. 8. Section 10607 of the Insurance Code is amended to read:*

10607. In addition to the other disclosures required by this chapter, every insurer and their employees or agents shall, when presenting a plan for examination or sale to any individual or the representative of a group ~~consisting of 25 or fewer individuals~~, disclose in writing the ratio of incurred claims to earned premiums (loss-ratio) for the insurer's preceding calendar year. ~~This section shall become operative on March 1, 1991, in order to allow insurers time to comply with its provisions~~ *for policies with individuals and with groups of the same or similar size for the plan's preceding fiscal year*.

~~SEC. 4.~~

*SEC. 9.* Chapter 8.1 (commencing with Section 10760) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 8.1. INSURANCE MARKET REFORM

~~10760. The requirements of this chapter shall apply notwithstanding any other provision of law.~~

~~10761.~~

*10760.* Effective July 1, 2008, every insurer that offers, markets, and sells health insurance to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board. A health insurer subject to this section may not exclude a potential insured from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1.

~~10762.~~

*10761.* (a) Every insurer that provides health insurance to residents of this state shall offer, market, and sell all of the uniform benefit plan designs made available through Cal-CHIPP pursuant to Part 6.45 (commencing with Section 12699.201) to purchasers in each region and all individual and group markets where the insurer offers, markets, and sells health insurance policies, consistent with statutory and regulatory rating and underwriting requirements applicable to the respective individual and group markets.

(b) This section shall not preclude an insurer from offering other benefit plan designs in addition to those required to be offered under subdivision (a).

~~10763.~~

*10762.* It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient's personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health insurers and providers shall adopt standard electronic medical records by January 1, 2012.

*10763. On and after January 1, 2008, all requirements in Chapter 8 (commencing with Section 10700) applicable to offering, marketing, and selling health benefit plans to small employers as*

*defined in that chapter, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the carrier's health benefit plan designs to all employers, guaranteed renewal of all health benefit plan designs, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that chapter, shall be applicable to all health benefit plan designs offered to all employers with 250 or fewer eligible employees, except as follows:*

*(a) For small employers with 2 to 50, inclusive, eligible employees, all requirements in that chapter shall apply.*

*(b) For employers with 51 to 250, inclusive, eligible employees, all requirements in that chapter shall apply, except that the carrier may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 250 eligible employees.*

*10765. (a) As used in this chapter, "health insurance" shall have the same meaning as in subdivision (b) of Section 106.*

*(b) The requirements of this chapter shall not apply to a Medicare supplement, vision-only, dental-only, or Champus-supplement insurance or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.*

~~SEC. 5.~~

*SEC. 10.* Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost family value package in a given geographic area.

(b) In each geographic area, the board shall designate one or more family value packages for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for

applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-five dollars ($25) per child with a maximum required contribution of seventy-five dollars ($75) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost family value package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost family value package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area

that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-two dollars ($22) per child with a maximum required contribution of sixty-six dollars ($66) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall

receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative law, is hereby extended to 180 days.

~~SEC. 6.~~

*SEC. 11.* Section 12693.55 is added to the Insurance Code, to read:

12693.55. (a) The board shall establish a premium assistance benefit for all individuals eligible under the program with incomes at or below 300 percent of the federal poverty level that maximizes federal financial participation, as follows:

(1) An individual eligible for benefits under the program who is offered health coverage by his or her employer shall enroll in the employer-offered health coverage on his or her own behalf and on behalf of his or her dependents, if any.

(2) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall not be responsible for any premium, deductible, or copayment requirements that are

greater than any premium, deductible, or copayment that the individual or dependent would be required to pay under the program, if any.

(3) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall be eligible for a wraparound benefit that covers any gap between the employer-offered health coverage and the benefits provided by the program.

(b) Notwithstanding subdivision (a), an employer of one or more employees who are required to enroll in employer-offered health coverage pursuant to this section may elect to pay the full premium cost of the program on behalf of all employees and their dependents who are eligible for the program. An employee whose employer elects to make this payment shall not be required to enroll in the employer-offered health coverage and shall instead enroll in the program.

(c) The premium assistance benefit under subdivision (a) shall only apply to individuals and their dependents if the board determines that it is cost effective for the state.

(d) Notwithstanding any other provision of law, this section may only be implemented on or after July 1, 2008, and only to the extent funds are appropriated for the purposes of this section in another statute.

~~SEC. 7.~~

*SEC. 12.* Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) [Reserved].

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). Commencing July 1, 2007, eligibility under this subparagraph shall not include infants during any time they are enrolled in employer-sponsored health insurance or are subject to an exclusion pursuant to Section 12693.71 or 12693.72, or are enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program, except during any time on or after July 1, 2007, that the infant is enrolled in employer-sponsored health insurance or is subject to an exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. Except as otherwise specified in this section, this enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level but less than or equal to 300 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 300 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 300 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) The applicant shall agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

(f) By January 2008, the board, in consultation with stakeholders, shall implement processes by which applicants for subscribers may certify income at the time of annual eligibility review, including rules concerning which applicants shall be permitted to certify income and the circumstances in which supplemental information or documentation may be required. The board may terminate using these processes not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the termination and shall include all relevant data elements that are applicable to document the reasons for the termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the board shall promptly provide any additional clarifying information regarding implementation of the processes required by this subdivision.

(g) Notwithstanding any other provision of law, the changes to this section made by the act adding this subdivision in the 2007–08 Regular Session of the Legislature may only be implemented on or after July 1, 2008, and only to the extent funds are appropriated for those purposes in another statute.

~~SEC. 8.~~

*SEC. 13.* Section 12693.73 of the Insurance Code is amended to read:

12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program, except as specified in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 and Section 12693.76, or except children who otherwise meet eligibility requirements for the program but for their immigration status.

~~SEC. 9.~~

*SEC. 14.* Section 12693.755 of the Insurance Code is amended to read:

12693.755. (a) Subject to subdivision (b), but no later than July 1, 2008, the board shall expand eligibility under this part to uninsured parents of, and as defined by the board, adults responsible for, children enrolled to receive coverage under this part whose income does not exceed 300 percent of the federal poverty level, before applying the income disregard provided for in subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70.

(b) (1) The board shall implement a program to provide coverage under this part to any uninsured parent or responsible adult who is eligible pursuant to subdivision (a), pursuant to the waiver or approval identified in paragraph (2).

(2) The program shall be implemented only in accordance with a State Child Health Insurance Program waiver or other federal approval pursuant to Section 1397gg(e)(2)(A) of Title 42 of the United States Code, or pursuant to the Deficit Reduction Act of 2005, Section 6044 of Public Law 109-171, to provide coverage to uninsured parents and responsible adults, and shall be subject to the terms, conditions, and duration of the waiver or other federal approval. The services shall be provided under the program only if the waiver or other federal approval is approved by the federal Centers for Medicare and Medicaid Services, and, except as

provided under the terms and conditions of the waiver or other federal approval, only to the extent that federal financial participation is available and funds are appropriated specifically for this purpose.

~~SEC. 10.~~

*SEC. 15.* Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM

12699.201. For the purposes of this part, the following terms have the following meanings:

(a) "Benefit plan design" means a specific health coverage product offered for sale and includes services covered and the levels of copayments, deductibles, and annual out-of-pocket expenses, and may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services that has significant incentives for the covered individuals to use the system.

(b) "Board" means the Managed Risk Medical Insurance Board.

(c) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" means the purchasing pool established pursuant to this part and administered by the board. The purchasing pool shall *only* be available to *employees of, and, if applicable, dependents of employees of* employers who elect to pay into the California Health Trust Fund ~~for coverage of~~ *in lieu of making health care expenditures for* their employees and, *if applicable,* dependents pursuant to Section 2200 of the Labor Code.

(d) "Participating health plan" means a health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code that contracts with the board to provide coverage in Cal-CHIPP and, pursuant to its contract with the board, provides, arranges, pays for, or reimburses the costs of health services for Cal-CHIPP enrollees.

12699.202. The board shall be responsible for establishing Cal-CHIPP and administering this part.

12699.203. (a) The board shall develop standards for high-quality coverage for Cal-CHIPP and negotiate favorable rates and contract with health plans by leveraging its purchasing power. Cal-CHIPP enrollees shall be offered a choice of health plans that provide comprehensive health care coverage, including medical, hospital, and prescription drug benefits. The board may establish health plan premiums and administer subsidies to eligible enrollees with incomes at or below 300 percent of the federal poverty level.

(b) The board shall develop and offer at least three uniform benefit plan designs to Cal-CHIPP enrollees. The three benefit plan designs shall include varying benefit levels, deductibles, coinsurance factors, or copayments, and annual limits on out-of-pocket expenses. In developing the benefit plan designs, the board shall do all of the following:

(1) Take into consideration the levels of health care coverage provided in the state and medical economic factors as may be deemed appropriate. The board shall include coverage and design elements that are reflective of and commensurate with health insurance coverage provided through a representative number of large insured employers in the state.

(2) Include in all benefit plan designs coverage for primary and preventive care services and prescription drugs, combined with enrollee cost-sharing levels that promote prevention and health maintenance, including appropriate cost sharing for maintenance medications to manage chronic diseases, such as asthma, diabetes, and heart disease.

(3) Consult with the Insurance Commissioner, the Director of the Department of Managed Health Care, and the Director of *the Department of* Health Care Services.

~~(c) The board shall directly mail to each Cal-CHIPP enrollee an information packet containing information about the available health plan choices.~~

12699.205. The board shall assume lead agency responsibility for professional review and development of best practice standards in the care and treatment of patients with high-cost chronic diseases, such as asthma, diabetes, and heart disease. Upon adoption of the standards, each state health care program, including, but not limited to, programs offered ~~by~~ under the Public

Employees' Medical and Hospital Care Act, Medi-Cal, Healthy Families, the ~~Managed~~ *Major* Risk Medical Insurance Program, and Cal-CHIPP, shall implement those standards.

12699.206. The California Health Trust Fund is hereby created in the State Treasury. The moneys in the fund shall be continuously appropriated to the board for the purposes of providing health care coverage pursuant to this part.

12699.207. The board, subject to federal approval pursuant to Section 14199.10 of the Welfare and Institutions Code, shall pay the nonfederal share of cost from the California Health Trust Fund for employees and dependents eligible under that federal approval.

~~SEC. 11.~~

*SEC. 16.* Section 12711.1 is added to the Insurance Code, to read:

12711.1. (a) The board shall establish a list of serious health conditions or diagnoses making an applicant automatically eligible for the program. In developing the list of conditions, the board shall consult with the Director of the Department of Managed Health Care and the commissioner to identify common health plan and insurer underwriting criteria.

(b) The board shall develop a standardized health questionnaire to be used by all health plans and insurers that offer and sell individual coverage. The questionnaire shall be designed to collect only that information necessary to identify if a person is eligible for coverage in the program pursuant to subdivision (a). Consistent with Section 1357.22 of the Health and Safety Code and Section 10762, health plans and insurers shall not deny coverage for any individual except for those who qualify for automatic eligibility for the program as determined by the board pursuant to this section.

~~SEC. 12.~~

*SEC. 17.* Part 8.8 (commencing with Section 2200) is added to Division 2 of the Labor Code, to read:

PART 8.8. EMPLOYER ELECTION

~~2200. Each employer shall elect to either arrange for the provision of health care for its employees, and if applicable, dependents, that is equivalent to at least ____ percent of total social security wages paid by the employer or to pay an equivalent amount to the California Health Trust Fund, created pursuant to~~

~~Section 12699.207 of the Insurance Code, as required by Section 976.7 of the Unemployment Insurance Code. The amount paid to the California Health Trust Fund by an employer shall be used to enroll the employer's employees and their dependents in the Cal-CHIPP purchasing pool pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.~~

~~2203. An employee working for an employer that elects to arrange for the provision of health care pursuant to Section 2200 shall be required to accept that arrangement, and an employee who does not select a health care option offered by the employer shall be automatically enrolled in the lowest-cost plan offered by the employer. However, an employee is exempt from this requirement if the employee is able to demonstrate that the employee is covered by other health care coverage, such as coverage made available by an employer to the employee's spouse that also covers the employee. In addition, an employee whose out-of-pocket costs for the employer-offered health care exceed ____ percent of the employee's family income may apply to the Managed Risk Medical Insurance Board to be relieved of this requirement. The board may relieve an employee of this requirement for up to one year if the employee demonstrates to the satisfaction of the board that the total premium and out-of-pocket costs pose an undue financial hardship.~~

*2200. (a) (1) Each employer shall elect to either (A) make health care expenditures as provided in paragraph (2) for its full-time or part-time employees, or both, and, if applicable, their dependents, or (B) pay an equivalent amount in either or both cases, as applicable, to the California Health Trust Fund, created pursuant to Section 12699.207 of the Insurance Code, as required by Section 976.7 of the Unemployment Insurance Code.*

*(2) (A) An employer's cumulative amount of health care expenditures for the employer's full-time employees working 30 or more hours per week shall be equivalent to ____ percent of social security wages paid by the employer to full-time employees.*

*(B) An employer's cumulative amount of health care expenditures for the employer's part-time employees working less than 30 hours per week shall be equivalent to ____ percent of social security wages paid by the employer to part-time employees.*

*(b) (1) The amount payable to the California Health Trust Fund by an employer electing to pay shall be deposited into the fund.*

*(2) The Employment Development Department, in consultation with the board, shall ensure that funds are deposited in the California Health Trust Fund pursuant to this section and are available to ensure the timely enrollment of eligible employees in the Cal-CHIPP purchasing pool.*

*(c) (1) The Employment Development Department shall adopt regulations that exempt businesses with payrolls of less than one hundred thousand dollars ($100,000) in a fiscal year, businesses with fewer than two employees, and new businesses during the first three years of the establishment of the business, from the requirements of this part. In adopting these regulations, the department shall deny the exemption to firms that restructure or reincorporate in order to avoid the requirements of this part.*

*(2) The Employment Development Department, in consultation with the board, shall adopt regulations determining the minimum number of hours per week a part-time employee must work in order to be subject to subparagraph (B) of paragraph (2) of subdivision (a) for purposes of the employer election in this section. The regulations shall exempt employers of part-time employees not working the required minimum number of hours from the requirements of this part.*

*2203. An employee working for an employer that elects, pursuant to Section 2200, to pay an equivalent amount in lieu of making health care expenditures shall be required to enroll in the California Cooperative Health Insurance Purchasing Program pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code to receive coverage from a participating health plan contracting with the board through the program. However, an employee is exempt from this requirement if the employee is able to demonstrate that the employee is covered by other group health care coverage, such as group coverage made available by an employer to the employee's spouse that also covers the employee.*

*2204. Unless the context requires otherwise, the definitions set forth in this section shall govern the construction and meaning of the terms and phrases used in this part:*

*(a) "Board" means the Managed Risk Medical Insurance Board.*

*(b) "Employer" means any individual, corporation, association, partnership, or limited liability company, or any agent thereof, doing business in this state, deriving income from sources within*

*this state, or in any manner whatsoever subject to the laws of this state, the State of California or any political subdivision or agency thereof, including the Regents of the University of California, any city organized under a freeholders' charter, or any political body not a subdivision or agency of the state, any person, officer, employee, department, or agency thereof, making payment of wages to employees for services performed within this state, consistent with regulations adopted pursuant to Section 2200.*

*(c) "Fund" means the California Health Trust Fund created pursuant to Section 12699.207 of the Insurance Code.*

*(d) "Health care expenditures" means any amount paid by an employer subject to this section to, or on behalf of, its employees and dependents, if applicable, to provide health care or health-related services or to reimburse the costs of those services, including, but not limited to, any of the following:*

*(1) Contributions to a health savings account as defined by Section 223 of the Internal Revenue Code.*

*(2) Reimbursement by the employer to its employees, and their dependents, if applicable, for incurred health care expenses, where those recipients have no entitlement to that reimbursement under any plan, fund, or program maintained by the employer. As used in this paragraph, "health care expenses" includes, but is not limited to, an expense for which payment is deductible from personal income under Section 213(d) of the Internal Revenue Code.*

*(3) Programs to assist employees to attain and maintain healthy lifestyles, including, but not limited to, onsite wellness programs, reimbursement for attending offsite wellness programs, onsite health fairs and clinics, and financial incentives for participating in health screenings and other wellness activities.*

*(4) Disease management programs.*

*(5) Pharmacy benefit management programs.*

*(6) Care rendered to employees and their dependents by health care providers employed by or under contract to employers, such as employer-sponsored primary care clinics.*

*(7) Purchasing health care coverage from a health care service plan or a health insurer.*

~~SEC. 13.~~

*SEC. 18.* Chapter 11 (commencing with Section 19900) is added to Part 10.2 of Division 2 of the Revenue and Taxation Code, to read:

CHAPTER 11. HEALTH CARE CAFETERIA PLAN

19900. This chapter shall be known and may be cited as the Health Care Cafeteria Plan.

19901. Unless federal law or the law of this state provides otherwise, each employer in this state during a taxable year shall adopt and maintain a cafeteria plan, within the meaning of Section 125 of the Internal Revenue Code, to allow employees to pay for health ~~benefits, including~~ *insurance* premiums, to the extent amounts for such benefits are excludable from the gross income of the employee under Section 106 of the Internal Revenue Code.

~~SEC. 14.~~

*SEC. 19.* Section 131 of the Unemployment Insurance Code is amended to read:

131. "Contributions" means the money payments to the Unemployment Fund, Employment Training Fund, California Health Trust Fund, or Unemployment Compensation Disability Fund that are required by this division.

~~SEC. 15.~~

*SEC. 20.* Section 976.7 is added to the Unemployment Insurance Code, to read:

976.7. In addition to other contributions required by this division and consistent with the requirements of Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code, an employer shall pay to the department for deposit into the California Health Trust Fund the amount required by Section 2200 of the Labor Code. These contributions shall be collected in the same manner and at the same time as any contributions required under Sections 976 and 1088.

~~SEC. 16.~~

*SEC. 21.* Section 14005.23 of the Welfare and Institutions Code is amended to read:

14005.23. (a) To the extent federal financial participation is available, the department shall, when determining eligibility for children under Section 1396a(*l*)(1)(D) of Title 42 of the United

States Code, designate a birth date by which all children who have not attained the age of 19 years will meet the age requirement of Section 1396a(*l*)(1)(D) of Title 42 of the United States Code.

(b) Commencing July 1, 2008, to the extent federal financial participation is available, the department shall apply a less restrictive income deduction described in Section 1396a(r) of Title 42 of the United States Code when determining eligibility for the children identified in subdivision (a). The amount of this deduction shall be the difference between 133 percent and 100 percent of the federal poverty level applicable to the size of the family.

~~SEC. 17.~~

*SEC. 22.* Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).

(3) To the extent federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code authorizing the state to disregard all changes in income or assets of a beneficiary until the next annual redetermination under Section 14012. The department shall implement this paragraph only if, and to the extent that the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to simplify eligibility for Medi-Cal under subdivision (a) by exempting all resources for applicants and recipients.

(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

(d) Commencing July 1, 2008, the department shall adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1(b)) and the amount equal to 133 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more generous than, and is substituted for, the earned income disregard available to recipients. Implementation of this subdivision is contingent upon federal financial participation. Upon implementation of this subdivision, the income disregard described in subdivision (c) shall no longer apply.

(e) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 and following) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title

2 of the Government Code. Beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

~~SEC. 18.~~

*SEC. 23.* Section 14005.33 is added to the Welfare and Institutions Code, to read:

14005.33. (a) (1) Notwithstanding Section 14005.30, to the extent that federal financial participation is available, Medi-Cal benefits under a benchmark plan as permitted under Section 6044 of the federal Deficit Reduction Act of 2005 (42 U.S.C. Sec. 1396u-7) shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) of Title 42 of the United State Code made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt an income disregard in an amount that is the difference between the Medi-Cal income eligibility established under subdivision (d) of Section 14005.30 and 300 percent of the federal poverty level applicable to the size of the family.

(b) The benchmark benefit plan referenced in subdivision (a) shall be equivalent to the coverage established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(c) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to simplify eligibility for Medi-Cal under subdivision (a) by exempting all resources for applicants and recipients.

~~SEC. 19.~~

*SEC. 24.* Section 14005.34 is added to the Welfare and Institutions Code, to read:

14005.34. Notwithstanding any other provision of law, all children under 19 years of age who meet the state residency requirements of the Medi-Cal program shall be eligible for full scope benefits under this chapter if they either (a) live in families with countable household income at or below 133 percent of the federal poverty level, or (b) meet the income and resource

requirements of Section 14005.7 or 14005.30, including those children for whom federal financial participation is not available under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

~~SEC. 20.~~

*SEC. 25.* Section 14008.85 of the Welfare and Institutions Code is amended to read:

14008.85. (a) To the extent federal financial participation is available, a parent who is the principal wage earner shall be considered an unemployed parent for purposes of establishing eligibility based upon deprivation of a child where any of the following applies:

(1) The parent works less than 100 hours per month as determined pursuant to the rules of the Aid to Families with Dependent Children program as it existed on July 16, 1996, including the rule allowing a temporary excess of hours due to intermittent work.

(2) The total net nonexempt earned income for the family is not more than 100 percent of the federal poverty level as most recently calculated by the federal government. The department may adopt additional deductions to be taken from a family's income.

(3) The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under the program established by Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).

(4) The parent is eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available and exercised by the state.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

~~SEC. 21.~~

*SEC. 26.* Section 14124.915 is added to the Welfare and Institutions Code, to read:

14124.915. (a) A premium assistance benefit shall be established that maximizes federal financial participation as follows:

(1) An individual eligible for benefits under this program who is offered health coverage by his or her employer shall enroll in the employer-offered health coverage on his or her own behalf and on behalf of his or her dependents, if any.

(2) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall not be responsible for any premium, deductible, or copayment requirements that are greater than any premium, deductible, or copayment that the individual or dependent would be required to pay under this program, if any.

(3) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall be eligible for a wraparound benefit that covers any gap between the employer-offered health coverage and the benefits provided by the program.

(b) Notwithstanding subdivision (a), an employer of an individual who is required to enroll in employer-offered health coverage pursuant to this section may elect to pay the full premium cost of this program on behalf of the employee and his or her dependents who are eligible for the program. An individual whose employer elects to make this payment shall not be required to enroll in the employer-offered health coverage, and shall instead enroll in this program.

(c) The premium assistance benefit under subdivision (a) shall only apply to individuals and their dependents when the State Department of Health Care Services determines that it is cost effective for the state.

~~SEC. 22.~~

*SEC. 27.* Article 7 (commencing with Section 14199.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 7. Coordination with the California Health Trust Fund

14199.10. The department shall seek any necessary federal ~~waiver~~ *approval* to enable the state to receive federal funds for coverage provided through the California Cooperative Health

Insurance Purchasing Program (Cal-CHIPP) to persons who would be eligible for Medi-Cal if the state adopted an additional income disregard as allowed by Section 1931(b) of the Social Security Act (42 U.S.C. Sec. 1396u-1(b)) sufficient to make persons with income up to 300 percent of the federal poverty level eligible for coverage under that section. Revenues in the California Health Trust Fund created pursuant to Section 12699.206 of the Insurance Code shall be used as state matching funds for receipt of federal funds resulting from the implementation of this section. All federal funds received pursuant to that ~~waiver~~ *federal approval* shall be deposited in the California Health Trust Fund.

~~SEC. 23.~~

*SEC. 28.* (a) Sections ~~3, 4, 11, and 21~~ *4, 9, 16, and 26* of this act shall become operative on July 1, 2008.

(b) Sections ~~10, 12, and 15~~ *15, 17, and 20* of this act shall become operative on January 1, 2009.

*SEC. 29. The Legislature finds and declares that Section 2 of this act, which amends Section 6254 of the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:*

*In order to maximize the ability of the Managed Risk Medical Insurance Board to implement agreements with health plans and to provide a wide choice of plans at minimal cost under the California Cooperative Health Insurance Purchasing Program created pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, it is necessary and appropriate to provide limited confidentiality to certain writings developed in that regard.*

~~SEC. 24.~~

*SEC. 30.* No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the

Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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**CORRECTIONS:**

**Digest—Page 3.**

**Text—Pages 15, 16, 32, and 33.**

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